Authorization for Use and Disclosure of Protected Health Information
(Instructions included)

INSTRUCTIONS

Greater Regional Health recogizes the patient's rights to access, use or disclose their protected health information. Protection of patient privacy is of the utmost importance for our patients as we follow all HIPAA rules and regulations. In order to process your request please follow the instructions below, fill out the below form, and allow 7 to 10 business days from receipt of your request in order to process.

All sections must be filled out.

Authorizations can be presented by the patient to the Health Information Management Department.

If the patient requests to mail, fax or email the authorization, it must be accompanied by a copy of a valid photo ID.

To Mail: Greater Regional Health
HIMS Department
1700 West Townline
Creston, Iowa 50801

To Fax: (641) 782-3522

To Email: request@greaterregional.org

If you have any further questions you can call us at 641-782-3520

Authorization for Use and Disclosure of Protected Health Information

Name *(First, Middle, Last):*	Birth date *(Month, DD, YYYY):*
Former Name *(If any):*	Rec. By:

Instructions: If any section is incomplete, this form may be invalid.

Release Information From

☐ GRH, 1700 W. Townline, Creston, IA 50801 or;
Facility: _____
Address: _____
_____
City: _____ State: _____
Phone#: _____ Fax#: _____

Release Information To

☐ GRH, 1700 W. Townline, Creston, IA 50801 or;
Person or Facility: _____
Address: _____
_____
City: _____ State: _____
Phone#: _____ Fax#: _____

Purpose of Release

☐ Treatment/Cont. of care ☐ Insurance ☐ Personal ☐ Legal Purposes
☐ Disability determination ☐ Research ☐ School
☐ Other*(specify)*_____

Information to be released *(please specify dates of service below):*

☐**Entire Record**		
☐Discharge summary	☐History and Physical	☐X-ray Record
☐Progress Notes	☐Lab reports	☐Cardiac Records
☐Operative report	☐Emergency Room Record	☐Clinic Record
Other *(specify):*		

Initial each line if you consent to include them in your records if applicable. I specifically authorize the release of information relating to: ___ Substance abuse (including alcohol/drug abuse) ___ Mental health or behavioral health ___ HIV related information (AIDS related testing) ***In order for this information to be released, you must initial beside each and sign below.**	**NOTICE:** This information has been disclosed to you from records protected By the Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I want to access my PHI from the following *dates of service*: _____

I understand the expiration date of this authorization is one year from the date signed unless otherwise specified here: _____. I understand that I may revoke this authorization at any time by notifying the disclosing organization in writing and it will be effective on the date the organziation receives the notification except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this use or disclosure of information, there will be no conditions of receiving further treatment of my healthcare. I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it. I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law. I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosure for the purpose of treatment, payment and operations.

Signature *(Required)*			**Date Signed** *(Required)* *(Month, DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*			
Mailing Address of Patient – Street			
City	State	ZIP Code	Phone